MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 30 April 2013 commencing at 8.45 am in the Board Room, MidCentral District Health Board

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PRESENT

Jack Drummond (chair)
Lindsay Burnell
Kate Joblin
Stephen Paewai
Barbara Robson
Phil Sunderland
Cynric Temple-Camp

In attendance
Murray Georgel, CEO
Mike Grant, General Manager, Planning & Support
Carolyn Donaldson, Committee Secretary

Barbara Cameron, Board Member
Karen Naylor, Board Member (part meeting)
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Lyn Horgan, Operations Director, Hospital Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Anne Amoore, Manager, Human Resources and Organisational Development
Sue Wood, Director of Nursing
Chris Channing, Business Manager, Planning & Support
Cushla Lucas, Service Manager, RCTS & BSCC
Carrie Naylor-Williams, Nurse Director Emergency, Hospital Coordination Services and Medical Assessment & Planning Unit
Communications (2)
Media (1)

1. APOLOGIES/RESIGNATION

An apology was received from Richard Orzecki.

Welcome

A welcome was extended to Barbara Cameron, new board member, who was attending the meeting as an observer.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

There were no amendments to the register of interests.

3.2 Declaration of conflicts in relation to today's business

The following declarations of conflict of interest were noted:

6.6

Jack Drummond and Cynric Temple-Camp declared a conflict of interest with some of the cases mentioned in the confidential section of the operating report. Cynric Temple-Camp also declared a conflict of interest in relation to item 6.5 due to reference about blood testing services.

Stephen Paewai declared a conflict in relation to items 6.2. 6.4. 7.1 and parts of item 17 (part 2 of the agenda) due to his directorships of Tararua Hauora Services and the Central PHO.

Barbara Robson declared an interest in relation to item 6.1 due to her membership of the MoH's Health Information Standards Organisation.

4. MINUTES

It was recommended

that the minutes of the meeting held on 19 March 2013 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

There were no matters arising from the minutes.

Work Programme – Cancer Services

Management confirmed they had advised the member concerned that the media discussion related to cervical screening not breast screening.

6. STRATEGIC/ANNUAL PLANNING

6.1 Regional Women's Health Unit – quarter 1 update

A member indicated it would be good to receive updates as work progressed in areas like outreach clinics, the maternity quality and safety programme and also privacy and security provisions. Management advised it had been decided as part of the annual planning work around child and mental health to report on such issues for the RWHS. One of the outcomes has been to set up a perinatal mental health working group. The secondary care Mental Health Service does support primary care and their focus was to understand the issues that arise in primary care and see how they can be developed by way of workforce development and support, bearing in mind that the secondary service also has responsibility for acute and complex needs. The group has been established and is getting under way.

The usefulness and enhancement of the video facilities for multidisciplinary team (MDT) meetings was noted, acknowledging that MDT meetings have been established for some time. Management clarified what the SharePoint information system was. The national maternity information system arose from the need across the country for improvement in the perinatal database system. The Ministry was leading the implementation, although MCH clinicians had been involved in the steering and reference groups being used to set it up.

Access to the DHB information systems by primary health was complex, due to the different systems being used by primary and secondary services and the ability to link them. The aim

was to upgrade the secondary service, and then have a single system accessible to both primary and secondary via the clinical portal (Concerto).

A concern was expressed by a member, that if confidentiality was taken to the extreme, there was potential to impact on patient care.

The future reporting process was outlined. There will be quarterly reporting during the development phase.

Management advised that the coordinator for the maternity quality and safety programme will report from the MCH Clinical Quality Department.

There was quite a lot of work to be done before any outreach clinics could be established, but it was hoped to get them underway by the end of the year.

It was recommended

that this report be received

6.2 Shorter Waits for Cancer Treatment

Management briefly outlined how the national and regional Picture Archive Communication Systems would work in terms of accessing patient information.

The governance work detailing how the multidisciplinary team (MDT) meetings would work has just started. This was being lead by the Project Manager for the Cancer Control Network. The MDT meetings were very resource rich, involving up to 35 people. The meetings were becoming more targeted with the people specifically required for each case attending meetings. There was an educational component from the meetings. Minutes were kept and circulated to all on the committee.

Stephen Paewai declared his interest as a director of the Central PHO and Rangitane o Tamaki nui a Rua, advising they had cancer nurses as part of their system, although his question did not relate to them.

He referred to the paragraph on page 6.10 which stated *"Five medical oncologists are now employed fulltime and are supported by two medical officers. A RCTS medical oncologist and medical officer are based at Hawke's Bay DHB, while remaining part of our medical oncology service operationally and collegially"* and asked how it worked. Were they employed by that DHB, our DHB, and did it happen in other services? He also referred to Chart 3 – DNA rates, saying he would have thought there was no relationship between DNA, Maori and others when there was a fall, or increase, they happened at the same time. Was something happening one month that was not happening another month? He left it at that.

Management explained that a few years ago, there were challenges recruiting medical oncologists, so MDHB had engaged with Hawke's Bay around how future services could be set up. The Hawke's Bay population was approximately a third of the population MDHB served, and there was a desire to strength the service. MDHB felt they should have dedicated resource, and Hawke's Bay was keen for that to happen. MDHB were fortunate to recruit a person who lived in Hawke's Bay but wanted to be part of MDHB's service. The arrangement has been very successful.

The only other similar instance were the Public Health Protection Officers who were based in Whanganui but worked for both Whanganui and MidCentral DHBs.

Management clarified that the exception codes, noted in paragraph 4 (page 6.8), were used to recognise that the turnaround of four weeks was not suitable for every individual cancer journey. The exception codes were valid reasons why a patient could not start within four weeks of the decision to treat.

A member referred to action point 3 of the annual plan action points. This action point related to patient referral when there was a "high suspicion of cancer". The member felt there would need to be really good referral guidelines. If every patient with a high suspicion

6.9

of caner was referred, the system would not be able to manage. Management agreed the expression was evolving in terms of practice. There was nothing to suggest there had been an impact on other referrals, and it was felt patients with a high suspicion of cancer were being treated appropriately.

It was recommended

that this report be received.

6.3 Progress in Delivering the Shorter Stays in Emergency Department Health Target update 2

The Chairman suggested it would be helpful to have a facility for a General Practitioner to work in the Emergency Department primarily to do GP work but also be exposed to procedures like putting in drips, cardiac arrests etc. Management advised that was happening at the moment, but the most useful time to have GP assistance would be when GPs were not available, ie at night. The impact of strengthening the ED doctor cover overnight had been to improve the patient safety and risk aspect, rather than speed up times.

Work was in progress to understand what the issues were around the Women's Health Service ED breaches. It apparently related to having the ability to respond in a timely fashion, and ensuring decisions were made as early as possible in terms of any general surgery or gynaecology required for the patient.

Karen Naylor joined the meeting.

Management confirmed the timing of the stay in ED finished when the patient was either admitted to a ward or left ED.

It was recommended

that this report be received.

6.4 Staff Culture Safety Survey quarterly update 2

A stock take tool and training package was being developed so teams can check themselves against what they have in place and what elements they need to focus on. A series of workshops was planned to assist with this. The tool and package will be shared with unions, the bipartite action group, and stock holders in the next few weeks.

Stephen Paewai declared his interest as a director of the Central PHO, and asked why, as a result of the mix and match process, the FTEs had been increased on a permanent basis in Ward 25 by five but budgeting had been for only two FTE. Management explained the model of care had changed when the Medical Assessment and Planning Unit (MAPU) was established. Shorter stay patients were being treated and discharged from MAPU, and that changed the staff mix required in the wards. Patients going into the wards were staying longer than one or two nights. In addition, Ward 25 now had two cohort rooms for patients who required additional specialling due to delirium or dementia etc. The mix and match process confirmed what had been happening in the ward. Permanently increasing the FTE staffing had a significant positive impact on staff and morale.

The Hospital at a Glance (HaaG) screens are in the main ward reception areas. The screens do not contain any patient information. They indicate likely discharge information and are used for planning purposes.

The bullying and harassment policy is being rolled out through the team development programme. The policy was available to staff, but it had not been widely publicised.

Management clarified that the third key theme "MDHB focused on financial results/targets" was one of the survey findings, whereby staff felt the DHB was too focused on financial targets. That particular aspect has been bedded down, and the organisation was now looking at investment planning.

It was recommended

that this report be received.

6.5 One Patient's Journey – progress report

Jack Drummond left the meeting.

Management spoke to the paper, noting that one of the key things not yet done was in relation to General Practice in Horowhenua.

Jack Drummond returned to the meeting.

The report was acknowledged as having a good primary/secondary approach.

It was recommended

that this report be received.

7. OPERATIONAL REPORTS

7.1 Provider Division Operating Report – March 2013

The resignation of Sue Wood, Director of Nursing, was noted with regret. Members extended their best wishes to Sue. Congratulations were also extended to the staff who had been successful in submitting various papers.

Management agreed to respond by email to the member who queried the necessity for two of the schools listed in appendix 7 (Contributing Schools) to travel.

There were not so many falls last month. The Falls Group continues to be active and analyse any falls.

Management advised there were currently only two neurologists managing a high workload. A third neurologist would arrive towards the end of June/beginning of July.

It was recommended

that this report be received

8. GOVERNANCE ISSUES

8.1 Work Programme 2012/13

Management referred to the forthcoming electives workshop, advising it was intended to cover the following:

- Context around the national electives programme
- The eight elective service performance indicators (ESPIs) and their criteria
- Progress in achieving the target, which is reducing to four months by December 2014. This will include access to assessment, demand, capacity, and will have clinical input.
- Referral management within MCH, communication to patients and primary providers (around inadequate referrals, declined referrals and monitoring of re-referrals). Access to treatment - thresholds, return to GP care and monitoring of patients would be covered as well.
- Overview of communication and district-wide systems around directory of services, waiting times, map of medicine linkages, and the central and national picture.
- On going reporting and outcome of the workshop.

Feedback from the meeting suggested the discussion on the ESPIs should be limited, as they were available on the web site.

6-10

There was a brief discussion on the time available for this workshop. Consequently, it was agreed that the Hospital Advisory Committee meeting would start at 8.30 am, and the workshop at 10.30 am.

It was recommended

that the updated work programme for 2012/13 be noted

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

11 June 2013

11. EXCLUSION OF PUBLIC

It was recommended

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report: : Potential Serious / Sentinel Events /	To protect personal privacy	9(2)(a)
Annual and Regional Planning update	Subject of negotiation	9(2)(j)
Quarterly Report 3 – Contracts	Subject of negotiation	9(2)(j)